reversed the district court's award of summary judgment in favor of the insurer holding that conflicting issues of fact in the record precluded summary judgment. However, the court nevertheless concluded that the district court had been acting within its discretion in limiting the scope of the evidence to what was before the plan administrator, Standard Insurance. Essentially the remand was for the purpose of holding a "trial" on the administrative record rather than a summary judgment proceeding. Dissenting and concurring opinions made it clear that there was abundant confusion as to just what the nature of de novo review on remand should be. Id 1096-1100. Judge Rinehart concurring in the result noted that the "litigation may benefit from a trial on the merits." Id. 1096. This discussion of circuit decisions pointing in various directions is foreshortened for purposes of this petition. The petitioner, however, respectfully suggests that this court owes it to circuit judges of good will to clarify the meaning of de novo review in *Firestone*. In reviewing decisions of lower courts one has a sense of inchoate unease about the fairness or unfairness of ERISA litigation. It may be that that unease reflects that the rules of civil procedure have been modified on an ad hoc basis without any articulated statutory or principled authority. There may be unease over the shift of adjudicatory authority from the courts to private plan administrators with a financial interest in the potential bias in the chance to skew the evidence they collect and sort, an integral and critical part of decision-making. Because the implications of the drift away from what one would ordinarily take to be a de novo consideration of a litigant's challenge to a benefit denial are largely unexamined it is difficult to say why there is such a scattering of opinion.

Here it is important to say what this petition is not about. It does not address the issue of whether an ERISA

plaintiff is entitled to a jury trial. Nor does it address the propriety of discretionary review when discretionary review is contractually reserved to a plan administrator. A clear understanding of what de novo review means is, however, necessary to an understanding of what any departures from that standard might entail.

It is one thing to rest foreshortened access to the courts on a contractual foundation, as parties often do with arbitration agreements. But when there is no contractual foundation for limiting access to the protections afforded by established rules of procedure one must consider whether a court could rest such limitations on statutory interpretation, the only alternative justification. The First Circuit did not explore the more fundamental issues raised by imposing ad hoc restrictions on judicial review.

It may be that the First Circuit interpreted ERISA's provision for a "full and fair" review of denied claims by plan administrators (29 U.S.C. § 1133 (b)) as a sufficient statutory delegation of authority to Paul Revere to justify denying the ordinary tools of litigation to an ERISA plaintiff. It is difficult to imagine what other justification there could be for such a shift in responsibility. However, that notion opens the door to due process challenges. For example, it could be argued that to the extent Paul Revere functions as an ERISA fiduciary and/or a plan administrator it is a creature of Congress and it derives its authority directly from ERISA's statutory provisions most especially 29 U.S.C. § 1133 (b). If the congressional mandate for the provision of a "full and fair review" is, however, interpreted to provide sufficient due process so that federal courts may dispense with full adjudication even in ERISA cases subject to de novo review there arises a serious constitutional issue. To the extent that the Paul Reveres of the ERISA world

assume the responsibility for gathering and sorting and weighing evidence in the first instance sufficient to relieve the courts of the problem they are exercising a traditional governmental function. The petitioner adds parenthetically that *Brentwood Academy v. Tennessee Athletic Association,* 531 U.S. 288 (2001) is most likely applicable to the role of private entities acting as ERISA fiduciaries and plan administrators in view of the governmental function performed especially if even de novo review permits the initial stages of litigation to be shifted from the federal courts to plan administrators. This is presented parenthetically because the petitioner's claim to de novo review rests on *Firestone* and the ordinary conception of de novo as implying plenary access to the courts. The petitioner does point out, however, that it is unlikely that the legislative delegation of "full and fair" review authority to a private insurance company with a financial stake in the outcome of the review process could ever survive constitutional scrutiny, if it were meant to substitute for the due process available to ordinary litigants in federal court. Disqualification of decision-makers with financial interests in the outcome of their decisions acting pursuant to governmental authority has a long history in constitutional jurisprudence. *Tumey v. Ohio,* 237 U.S. 510 (1929); *Ward v. City of Monroeville,* 409 U.S. 57 (1971); *Gibson v. Berryhill,* 411 U.S. 564 (1973) and *Aetna Life Ins. Co. v. Lavoie,* 475 U.S. 813 (1986) are all cases in which decisions were held void because they were made by decision-makers acting under the authority of law but who could also be said to possess a financial interest in the outcome of their decision-making, even though that interest might not even be direct.

Law does not exist in a vacuum. It is worth looking at the practical consequences of the denial of discovery, of the ability to introduce evidence in court and of the ability to

have a hearing in federal court. It turns out that during the course of Orndorf's litigation the U.S. Department of Labor and the relevant insurance regulators in Maine, Massachusetts, and Tennessee were conducting an extensive investigation of UnumProvident's claims practices (UnumProvident Corporation employees actually process claims for all UnumProvident subsidiaries including Paul Revere). The report of this examination of Paul Revere's claims processing describes systemic biases sufficient to warrant the imposition of a "settlement agreement" upon UnumProvident companies requiring, among other things, that approximately 212,000 claimants be given the opportunity to have their claims reviewed. The report appears in the Appendix to this petition. A-39-69. Excluded from those entitled to have their claims reviewed are those who had benefit denials upheld in federal court. Yet the denial of discovery to the petitioner erased the possibility of uncovering the biases inherent in the respondent's claim processing. While the court of appeals suggests it reviewed the record assembled by Paul Revere de novo, it necessarily deferred to Paul Revere's selection of its own medical evidence from employee physicians as having more evidentiary weight than medical evidence favoring Orndorf's claim. No issue of the credibility of the source of the evidence could be raised. Among these specific findings of the regulatory report is the following:

> Excessive reliance upon in-house medical professionals also suggests the companies' employment of such professionals often resulted in a company bias and the inappropriate interpretation or construction of medical reports to the detriment of claimants. In certain instances this bias was reflected in the interpretation of attending physicians' statements or medical records supplied by attending

> physicians. In other instances in which the companies had obtained an IME (independent medical exam) the reports supplied by the IME providers were narrowly or even incorrectly construed. The bias of the in-house medical professionals was also reflected in attempts to focus upon any apparent inconsistencies in the medical records or other information supplied by claimants, rather than attempt to derive a thorough understanding of the claimant's medical condition. A-49.

The regulatory agencies and the UnumProvident companies remained silent about the investigation and about preliminary results until the entire report was released along with an accompanying settlement agreement on November 18, 2004. Whether the petitioner would have been successful in any challenge to the medical evidence had discovery been available remains unknown. Certainly the preliminary regulatory findings of a biased claims process should have been uncovered in the face of the right questions. What is known is that the preclusion of discovery prevented even the possibility of a successful challenge and that suggests an inherent unfairness in the decision of the court below.

CONCLUSION

The decision of the First Circuit in this case marks an extreme in the continuum between affording plenary judicial review to ERISA litigants entitled to de novo review in accordance with this Court's decision under Firestone and those Courts which deny such review. The petitioner respectfully submits that it is time for the Supreme Court

itself to examine what should be meant by the de novo review which it held to be the default standard of review in *Firestone*.

Respectfully Submitted,

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404 FEDERAL REPORTER, 3d SERIES

Jacob M. ORNDORF, Plaintiff,
Appellant,

v.

PAUL REVERE LIFE INSURANCE COMPANY, Defendant,
Appellee.

No. 04–1520.

United States Court of Appeals,
First Circuit.
Heard Jan. 5, 2005.
Decided April 15, 2005.

Background: Claimant brought action under Employee Retirement Income Security Act (ERISA) alleging that insurer unlawfully denied his claim for long-term disability benefits due to physical limitations. The United States District Court for the District of Massachusetts, Michael A. Ponsor, J., granted summary judgment for insurer. Beneficiary appealed.

Holdings: The Court of Appeals, Lynch, Circuit Judge, held that:

(1) evidence outside of administrative record was not admissible;

(2) claimant was not entitled to discovery after seeking review; and

(3) claimant did not meet his burden of showing that back pain disabled him from operating heart-lung machine.

Affirmed.

1. Labor and Employment ➵686

Under ERISA, de novo review by the district court of a plan administrator's decision to deny benefits under an ERISA plan is proper where the plan does not grant discretion to the administrator. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

2. Labor and Employment ➵686

Where ERISA case was decided on summary judgment in district court, standard of review used by Court of Appeals to review district court's decision was de novo, and included non-deferential review of legal question of proper content of district court's de novo review of plan administrator's determination. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.; Fed. Rules Civ.Proc.Rule 56, 28 U.S.C.A.

3. Federal Civil Procedure ➵2497.1

In an ERISA case, where review is based only on the administrative record before the plan administrator and is an ultimate conclusion as to disability to be drawn from the facts, summary judgment is simply a vehicle for deciding the issue; this means the non-moving party is not entitled to the usual inferences in its favor. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.; Fed.Rules Civ.Proc.Rule 56, 28 U.S.C.A.

4. Federal Civil Procedure ➵2497.1

When there is no dispute over plan interpretation, the use of summary judgment simply as a vehicle for deciding the issue of eligibility is proper, without giving the non-moving party the usual inferences in its favor, regardless of whether review of the ERISA decision maker's decision is de novo or deferential. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.; Fed.Rules Civ.Proc.Rule 56, 28 U.S.C.A.

5. Labor and Employment ➵686

Proper content of district court's de novo review of ERISA plan administrator's decision denying benefits included conclusion to deny benefits based on set of facts. Employee Retirement Income Security Act of 1974, § 502(a)(1)(B), 29 U.S.C.A. § 1132(a)(1)(B).

6. Labor and Employment ➵439

Where there is no dispute over the meaning of language in an ERISA plan, no deference is given to the administrator's interpretation of the plan language; rather, the court interprets the plan de novo, and applies the normal rules for contract interpretation. Employee Retirement Income Security Act of 1974, § 502(a)(1)(B), 29 U.S.C.A. § 1132(a)(1)(B).

7. Jury ➵14(1.4)

Where review of an ERISA plan administrator's decision denying benefits under an arbitrary and capricious standard is based on an administrative record and no additional evidence is considered, jury trials are not available. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

8. Labor and Employment ⇒686, 691

The fact that judicial review of an ERISA plan administrator's decision denying benefits is de novo does not itself entitle a claimant to a trial or to put on new evidence. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

9. Labor and Employment ⇒685

Trial is not warranted of an ERISA plan administrator's decision denying benefits because the record shows one doctor's diagnosis disagrees with another doctor's. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

10. Labor and Employment ⇒691

Review of the ultimate conclusion under ERISA of whether the evidence supports the finding of a disability does not itself warrant introduction of new evidence about historical facts. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

11. Labor and Employment ⇒686

Under ERISA, de novo review generally consists of the court's independent weighing of the facts and opinions in that record to determine whether the claimant has met his burden of showing he is disabled within the meaning of the policy. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

12. Labor and Employment ⇒691

Where claimant had not been denied opportunity to present evidence to administrator, evidence outside of administrative record was not admissible on review of question of whether claimant was disabled, even when denial of benefits was subject to de novo review under ERISA.

Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

13. Federal Civil Procedure ⇒1264

Claimant was not entitled to discovery after seeking review of ERISA plan administrator's benefits decision, regardless of whether standard of review was de novo or deferential, without serious claim of bias or procedural misconduct. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

14. Labor and Employment ⇒629(2)

Claimant did not meet his burden of showing that back pain disabled him from operating heart-lung machine, for purpose of his claim for long-term disability benefits under ERISA plan, where claimant actually operated that machine without any physical limitations despite 20 years of back pain and treatment, claimant stopped working because of his drug dependency, claimant's back pain was controllable and it did not prevent him from working, claimant engaged in recreational and life activity inconsistent with his claim of disability, and back disability claim was not made at all until claimant had only two years of disability payments remaining from his drug dependency claim. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

15. Labor and Employment ⇒618

Under ERISA, a letter denying benefits need not detail every bit of information in the record; it must have enough information to render the decision to deny benefits susceptible to judicial review. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

16. Labor and Employment ➵629(2)

ERISA does not require plan administrators to accord special deference to opinions of treating physicians. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

17. Labor and Employment ➵629(2)

Under ERISA, denials of benefits may be based on review of medical records submitted by the claimant. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

Charles Leonard Mitchell for Appellant.

Joan O. Vorster, with whom Elizabeth L.B. Greene and Mirick, O'Connell, DeMallie & Lougee, LLP were on brief, for Appellee.

Before TORRUELLA, Circuit Judge, CAMPBELL, Senior Circuit Judge, and LYNCH, Circuit Judge.

LYNCH, Circuit Judge.

This case requires us to address what is meant by de novo judicial review under ERISA of a denial of benefits when the ERISA plan does not preserve discretion in the plan administrator. That raises concomitant questions of whether the claimant is entitled to trial in the district court and what, if any, evidence may be admitted that is not in the administrative record before the ERISA administrative decision maker. Our conclusion is that given the nature of the claimant's challenge here—that he did in fact establish his eligibility to benefits before the ERISA decision maker—the claimant was not entitled to trial or to admit desired new evidence outside the administrative record or to

discovery. Having defined the standards, we apply them to the facts, and uphold the denial of benefits.

I.

Jacob Orndorf worked as a perfusionist, a person who operates a heart-lung machine, for Jersey Shore Cardiac Associates, Inc. ("Jersey Shore") from January 1, 1992 until March 29, 1995. Defendant Paul Revere Life Insurance Company ("Revere") provides group long-term disability insurance coverage to Jersey Shore; this plan is an employee welfare benefit plan as defined by ERISA.

In June 1995, Orndorf started receiving disability benefits for his drug dependency; under the policy, these benefits would last only until June 26, 2000. In 1998, Orndorf first informed Revere that he claimed a continuation of the disability payments beyond June of 2000 based on purported back problems. There was considerable exchange of medical information between Orndorf and Revere. Revere determined that Orndorf was not disabled due to pain from his back, neck, ankle or hypertension. On January 10, 2002, Revere issued a final denial of benefits and informed Orndorf that he had exhausted all of his appellate administrative remedies and that Revere would review no further information; the administrative record was closed.

In February of 2002, Orndorf[1] filed suit against Revere[2] in federal district court pursuant to 29 U.S.C. § 1132(a)(1)(B), alleging that Revere unlawfully denied his claim for long-term disability benefits due to physical limitations. Both parties filed motions for summary judgment.

The district court extensively reviewed the evidence in the administrative record, the duties of someone in Orndorf's occupation, Orndorf's first claim (drug dependency) and second claim (back pain) for disability, his treatment for back pain, his capacity to work, Revere's conclusion, and Orndorf's arguments on appeal. The court concluded that Orndorf was not disabled due to back, neck, or ankle pain or hypertension under the terms of the plan;[3] "Orndorf's claim collapsed under the weight of the Record." The court granted summary judgment to Revere on March 17, 2004. *Orndorf v. Paul Revere Life Ins. Co.*, No. 02–30024 (D.Mass. Mar. 17, 2004).

II.

A. The Policy

The Revere long-term disability policy at issue provides benefits in certain situations, including when an

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[1]In several letters and papers in the administrative record, the appellant's name is spelled "Orndorff." However, the complaint and other papers filed in the district court and the briefs before this court use the spelling "Orndorf," and that is the spelling we use in this opinion.

[2]Unum Provident was originally named as a defendant, but on September 16, 2002, the parties stipulated that Revere was the proper and sole defendant.

[3]The hypertension claim has been dropped on appeal.

individual is totally disabled from performing the duties of his or her own occupation. Total disability for the purposes of Orndorf's policy means:

> a. that because of injury or sickness the employee cannot perform the important duties of his own occupation; and b. the employee is under the regular care of a doctor; and c. the employee does not work at all.
>
> The policy also defines Revere's obligation to pay benefits to the employee: [Revere] pay[s] monthly total disability benefits to an employee if he becomes totally disabled while insured due to injury or sickness. The employee must be under the care of a doctor while totally disabled... During any continuous period of disability immediately following completion of the employee's elimination period, but before the end of his benefit period, [Revere] pay[s] the employee a monthly total disability benefit for each whole month in which he is totally disabled from his own occupation. If the employee works other than full-time at his own job, he may qualify for monthly residual disability benefits.

B. Orndorf's First Claim for Disability

In May of 1995, Orndorf submitted his first claim to Revere for disability benefits for a "drug related" sickness, following hospitalization for a drug overdose. Revere evaluated Orndorf's records to determine whether he was totally disabled due to drug disability under the plan, and on August 24, 1995, Revere informed Orndorf that it had

approved his claim under the "Other Limitations" provision of the Policy and that his benefits period would expire on June 26, 2000.[4]

Although Orndorf is no longer receiving payments for this disability, his drug and psychiatric illnesses continue to preclude him from returning to his job as a perfusionist.[5] One might ask why, if Orndorf is disabled anyway from doing his job as a perfusionist, there is any issue about whether he is also disabled by his back condition. There are two answers. The first is that Revere's statement of reasons as to why it denied benefits is that (1) the benefit period for

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[4]The plan contains special limitations for "any disability caused or contributed to by a psychiatric condition, alcoholism or drug abuse," such as Orndorf's disability. First, "an employee will be considered to be disabled [under the policy] only if he is satisfactorily participating in a program of treatment or rehabilitation approved by us." Second, for this kind of disability, benefits are limited: "benefits are payable for up to sixty months whether or not the employee is hospital confined. After sixty months, subject to all other policy provisions, [Revere] pay[s] benefits only if the employee continues to be hospital confined due to the disability."

[5]As the district court found, "it is undisputed that [Orndorf's] drug dependency will be a lifelong condition and will prevent Orndorf from ever returning to his occupation as a perfusionist..." This is consistent with the evidence in the administrative record, including Orndorf's own admission. Orndorf stated, "[A]ddiction is a lifetime illness, this means limiting my access to medications for ever [sic]... [I] would love to work again in the [medical] field, but my illness makes this impossible."

On appeal, Orndorf in his brief suggests that perhaps he could return to his work as a perfusionist despite his addiction. Orndorf cites to several websites which he states give examples of and information about health care providers recovering and returning to practice. This information was not before the administrator and was not admitted by the district court. We note but do not consider it.

the drug dependency disability had expired and (2) the information provided did not support eligibility for disability under any other provision of the plan. Revere is limited to the grounds of denial it articulates to the claimant. *See Glista v. Unum Life Ins. Co.*, 378 F.3d 113, 128–29 (1st Cir.2004). Second, Orndorf cites to a provision in the policy that provides for circumstances where an employee is disabled by more than one injury or sickness:

> If a Disability is caused by more than one Injury or Sickness, or from both, We will pay benefits as if the Disability was caused by one Injury or Sickness... We will pay the larger benefit.

Revere has not disputed the applicability of this provision to Orndorf's case.

There is no real dispute that Orndorf was paid the benefits owed for his first disability claim due to drug dependency.[6]

The question is whether he was disabled within the meaning of the policy for his alleged back condition, his second claim for disability.

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[6]Before the district court, Orndorf argued that Revere's termination of his benefits for his drug related disability was arbitrary and in breach of Revere's fiduciary duty. The district court summarily rejected this argument, noting that "no evidence in the Record indicates that Paul Revere failed to pay Orndorf the full amount of the benefits owed to him as a result of his initial disability claim based on drug dependency." The district court concluded, "there is no merit to Orndorf's claim that Revere's decision to 'terminate' his benefits was arbitrary, capricious, and in breach of a duty of good faith and a fiduciary duty." Orndorf does not raise this issue or dispute this finding on appeal.

C. Orndorf's Second Claim for Disability

Although Orndorf says his history of back pain dates back to 1976, Orndorf first claimed disability on account of his back pain in June of 1998, when a Revere field representative met with Orndorf at his home on an unannounced visit. During this visit, Orndorf claimed that his chief disabling condition was his back and that therefore the disability payments should continue beyond June of 2000. Soon thereafter, Revere obtained Orndorf's complete Social Security Disability Insurance Appeal decision and his medical records.

In December of 1999, the insurer issued its original decision on this second claim, and Orndorf was told that his benefits were denied:

> In the regular course of administering your claim, we conducted a review of all of your medical records. As a result of this review, it is our opinion that you are not precluded from performing the duties of your job or one similar in nature.
>
> You alleged that you could not work due to chronic low back pain and advised your doctor on June 23, 1998 that your activities were limited and you remained indoors most of the time. However, on June 11, 1998, you reported you had been on a long bike ride. There seems to be some discrepancy between your related history and limitations and your actual level of activities and your performance.

> We found no evidence of back problems or hypertensive care during the year 1998. Consequently, it is our opinion that your only disabling condition has been depression and substance abuse. Therefore, your claim has been administered and paid under the Other Limitations provision of the policy.

In October of 2000, on the first review of its denial, the insurer advised Orndorf:

> We have received your letter dated October 3, 2000 including a letter from Dr. Gilbert. Your entire claim file was sent to our medical department for review, the review included the following records: medical review from Dr. Bianchi, medical packet from you backdated 8/31/00, letter from Dr. Rund dated 11/1/97, a functional capacity form completed by Dr. Gilbert, CT lumbar spine dated 3/8/00 and x-rays of spine and cervical dated 5/12/00.
>
> At this time it is our opinion that in order to fully evaluate your physical limitations and restrictions we need additional objective information. This information should include reports of your last examination from the reported date of your illness and updated physical examinations.

On August 23, 2001, the insurer affirmed its denial of benefits on the basis that:

> These records were reviewed by one of our in-house physicians. This physician is

> Board–Certified in Internal Medicine. We have determined that based on [ ] Mr. Orndorf's medical records that there was no basis for hypertensive impairment, and no evidence of persistent impairment producing limitations or necessitating restrictions from Mr. Orndorf's maxillary sinusitis and cervical spine complaints.

Thereafter, at Ordnorf's request, the insurer considered additional evidence and on January 10, 2002, reaffirmed its denial in a final review:

> Since additional information was submitted, Mr. Orndorf's file was forwarded to the medical department for review. According to the Board–Certified Physician in Internal Medicine, he concludes the following:
>
> a) Primary psychiatric impairment at the date of disability with persistence demonstrated through much of the claim period without adequate objective documentation of persistence to or beyond the 12/21/99 determination letter
>
> b) No objective basis for hypertensive impairment producing limitations or necessitating restrictions at or below a high-level medium workload
>
> c) Degenerative disc disease of the lumbar spine with intermittent symptomatic exacerbations without evidence of continuous or persistent ongoing impairment through the

life of the claim, at or about the 12/21/99 determination letter, or subsequently

d) Post-traumatic ankle pathology without objectively demonstrated standing or ambulatory impairment during the course of the claim beyond transiently associated with the 11/99 sprain and specifically without evidence of continued or persistent impairment from the 12/21/99 determination letter up to the 5/3/00 rating examination

e) No objective evidence of continued or persistent impairment producing limitations necessitating restrictions from the claimant's maxillary sinusitis and cervical spine complaints. Based on the information in the claim file, the denial of benefits in Mr. Orndorf's case is appropriate.

Orndorf then filed suit in the district court.

III.

On appeal, Orndorf raises several challenges to the district court's decision, arguing the district court erred by (1) failing to use de novo review in ruling on the cross motions for summary judgment; (2) denying Orndorf's request for discovery and leave to submit additional evidence; (3) denying Orndorf's motion for summary judgment or, in the alternative, in failing to find a material dispute of fact which would have defeated Revere's motion; and (4) not awarding Orndorf interest, attorney's fees, and costs. If Orndorf is wrong about the first three claims, the fourth necessarily fails.

[1] Both parties agree that de novo review by the district court of a plan administrator's decision to deny benefits under an ERISA plan is proper under *Firestone v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), where the plan does not grant discretion to the administrator.[7] The overarching question is what exactly is entailed in de novo review.

A. Appellate Standard of Review

[2] We quickly put aside one issue about the scope of our appellate review. Because the case was decided on summary judgment in the district court, the standard of review used by this court to review the district court's decision is de novo. *See Fenton v. John Hancock Mut. Life Ins. Co.*, 400 F.3d 83, 87 (1st Cir.2005). This includes our engaging in non-deferential review of the legal question of the proper content of the district court's de novo review of a plan administrator's determination, as that term is used in *Firestone v. Bruch*, 489 U.S. at 115, 109 S.Ct. 948.

[3, 4] The review utilized both by this court and the district court in this ERISA case differs in one important aspect from the review in an ordinary summary judgment case. As we noted in *Liston v. Unum Corp. Officer Severance Plan*, 330 F.3d 19 (1st Cir.2003), in an ERISA case where review is based only on the administrative record before the plan administrator and is an ultimate conclusion as to disability to be drawn from the facts, summary judgment is simply a vehicle for deciding the issue. *Id.* at 24.

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[7] *Firestone* held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone*, 489 U.S. at 115, 109 S.Ct. 948.

This means the non-moving party is not entitled to the usual inferences in its favor. *Id.* When there is no dispute over plan interpretation, the use of summary judgment in this way is proper regardless of whether our review of the ERISA decision maker's decision is de novo or deferential.[8]

B. Content of De Novo Standard of Review

[5] Plaintiff's argument as to the proper content of the district court's de novo review is based on the second paragraph of *Firestone's* holding, set forth below:

> As this case aptly demonstrates, the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue.
>
> Consistent with established principles of trust law, we hold that a *denial of benefits* challenged under § 1132(a)(1)(B) *is to be reviewed under a de novo standard* unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.

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[8]To the extent *Radford Trust v. First Unum Life Insurance Company of America*, 321 F.Supp.2d 226, 239 (D.Mass.2004), suggests otherwise, we disagree. It cites to *Hughes v. Boston Mutual Life Insurance Company*, 26 F.3d 264, 268 (1st Cir.1994), a case concerned with the different issue of application of summary judgment rules to interpretation of ambiguities in an ERISA contract. *Id.* at 270. For a discussion of the interplay of contract and summary judgment rules, see *McAdams v. Massachusetts Mutual Life Insurance Company*, 391 F.3d 287, 298–300 (1st Cir.2004).

Firestone, 489 U.S. at 115, 109 S.Ct. 948 (emphasis added).

[6] Firestone makes it clear that in such situations of dispute over the meaning of plan language, no deference is given to the administrator's interpretation of the plan language. Rather, the court interprets the plan de novo, and applies the normal rules for contract interpretation. *See Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264, 267–68 (1st Cir.1994). In this case, there is no dispute about interpretation of the plan terms presented on appeal.[9] Thus there is no occasion to consider the use of outside evidence to assist the court in interpreting plan language. There is also no dispute over what the plan documents are. *Cf. Fenton*, 400 F.3d at 87–89. But literally read, *Firestone's* de novo review language is broader, and also includes a conclusion to deny benefits based on a set of facts, such as Revere's conclusion here.

From *Firestone's* de novo review language, Orndorf makes several arguments.

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[9]Orndorf asserts in his brief that Revere applied the wrong standard of total disability by stating in its first denial of Orndorf's disability claim that "it is our opinion that you are not precluded from performing the duties of *your job or one similar in nature*." (emphasis added). But Orndorf makes no serious argument that Revere misinterpreted the policy or that Revere ultimately applied this definition of disability as opposed to the one which requires that Orndorf cannot perform the important functions of his own profession. It is clear that this is the definition Revere applied in making its final determination that Orndorf was not entitled to disability. In the September 2000 review by Revere, the reviewer was specifically asked whether the insured was precluded from performing the duties of his *own* occupation, which was listed as perfusionist. In the August 2001 review, Revere asked what the reviewer's prognosis was for Orndorf's return to work; his occupation was listed as perfusionist.

Orndorf argues that the district court erred by giving deference to the administrator's decision. The correct standard, he argues, is "whether, upon a full review of the administrative record, the decision of the administrator was correct." We agree with this standard and disagree that the district court used any other standard.

[7–9] Orndorf next argues that if the administrative record shows any conflict in views among the doctors, then summary judgment must be denied. Orndorf may be arguing that on review of an administrative record through summary judgment the court must relieve him of his burden of proving he is disabled because under summary judgment all inferences are drawn against the movant. We have already rejected this argument in *Liston*, 330 F.3d at 24, and we apply *Liston* to de novo review, as noted above. Alternatively, Orndorf may be arguing that a court faced with an administrative record with conflicting medical opinions should then hold a trial with witnesses to resolve the disputes. He filed a motion to that effect, which was denied by the district court. The court was correct to deny the motion. Trial is not warranted because the record shows one doctor's diagnosis disagrees with another's, and the fact that judicial review is de novo does not itself entitle a claimant to a trial or to put on new evidence.[10]

Some courts have stated that "factual findings" made by the administrative decision maker are reviewed de

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[10]By analogy, we have held where review (under an arbitrary and capricious standard) is based on an administrative record and no additional evidence is considered, jury trials are not available. *See Recupero v. New Eng. Tel. & Tel. Co.*, 118 F.3d 820, 831 (1st Cir. 1997). Again, the change in standard of review from arbitrary and capricious review under *Recupero* to de novo review in this case makes no difference.

novo and have suggested that this warrants the introduction of new evidence to the trial court, perhaps in the form of an evidentiary hearing or a trial de novo. *See Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176, 1184–85 (3d Cir.1991). Where review is properly confined to the administrative record before the ERISA plan administrator, as we explain below is the case here, there are no disputed issues of fact for the court to resolve.

[10, 11] Review of the ultimate conclusion of whether the evidence supports the finding of a disability does not itself warrant introduction of new evidence about historical facts. *See Masella v. Blue Cross & Blue Shield, Inc.*, 936 F.2d 98, 104 (2d Cir.1991). Nor does it warrant calling as witnesses those persons whose opinions and diagnosis or expert testimony and reports are in the administrative record. Rather, de novo review generally consists of the court's independent weighing of the facts and opinions in that record to determine whether the claimant has met his burden of showing he is disabled within the meaning of the policy. While the court does not ignore facts in the record, *see Recupero v. New Eng. Tel. & Tel. Co.*, 118 F.3d 820, 830 (1st Cir.1997), the court grants no deference to administrators' opinions or conclusions based on these facts.

One guiding principle in conducting de novo review of this ultimate conclusion is that it is the plaintiff who bears the burden of proving he is disabled. *See Terry v. Bayer*, 145 F.3d 28, 34 (1st Cir.1998) (insured bears burden of making showing sufficient to establish a violation of ERISA); *GRE Ins. Group v. Met. Boston Hous.*, 61 F.3d 79, 81 (1st Cir.1995).

C. Extra–Administrative Record Evidence

[12] Orndorf also argues that the trial judge should have admitted evidence outside of the administrative record on the question of whether he was disabled. He argues the trial court erred:

> in denying [him] leave to submit evidence of significant weight gain of 80 pounds, medical records of his need for gastronomy for weight loss, records of his prescribed pain killers for pain reduction such as oxycodene and clonazepon, a MRI showing disc change and nerve compromise, and a medical report from Dr. Marc Linson, an orthopedic spine specialist, who examined Orndorf and his records and opined that he was disabled on January 10, 2002, the date of Revere's denial and at the time of the examination one year later.

Not only do we reject Orndorf's claim that it was error for the court to exclude such extra-record medical evidence, but we hold it would have been error for the court to have admitted such evidence.

The decision to which judicial review is addressed is the final ERISA administrative decision. It would offend interests in finality and exhaustion of administrative procedures required by ERISA to shift the focus from that decision to a moving target by presenting extra-administrative record evidence going to the substance of the decision. *Liston*, 330 F.3d at 24. There is no claim Orndorf was denied an opportunity to present evidence to the administrator. Here, the plaintiff had ample time to collect records and had two administrative appeals reviews of his

claims by Revere. Even if the new evidence directly concerned the question of his disability before the final administrative decision, it was inadmissible.

Furthermore, the final administrative decision acts as a temporal cut off point. The claimant may not come to a court and ask it to consider post-denial medical evidence in an effort to reopen the administrative decision. The evidence Orndorf sought to introduce is of this character.

As this court noted in *Liston*, the focus of judicial review, under the arbitrary and capricious standard, is ordinarily on the record made before the administrator and at least some very good reason is needed to overcome that preference. *Id. Liston* did not resolve the question of whether the same rule applies when there is de novo review, but did note that even in de novo review cases it was:

> at least doubtful that courts should be in any hurry to consider evidence or claims not presented to the plan administrator... Exhaustion of remedies principles point in this direction even if *no* deference were due to the administrator's determination, assuming always that the plan empowered the administrator to make an initial decision.

Id. (citation omitted).

We hold that the *Liston* rule about admissibility of evidence outside the administrative record applies even when the denial of benefits is subject to de novo review. Whether evidence is admissible turns on the nature of the challenge to the decision; the answer to the question is not likely to turn on whether the standard of judicial review is de novo or arbitrary and capricious. The focus of the review

under de novo review is still the administrator's decision and must ordinarily be based on the administrative record.

There may be times when it is appropriate for courts to hear new evidence. Where the challenge is not to the merits of the decision to deny benefits, but to the procedure used to reach the decision, outside evidence may be of relevance. For example, evidence outside the administrative record might be relevant to a claim of personal bias by a plan administrator or of prejudicial procedural irregularity in the ERISA administrative review procedure. *See id.* at 23. We need not catalogue the situations in which new evidence is admissible, other than to note it is more obviously relevant when the attack is on the *process* of decision making as being contrary to the statute than on the substance of the administrator's decision. Also, evidence may be relevant to explain a key item, such as the duties of the claimant's position, if that was omitted from the administrative record. Such explanatory extrinsic evidence was admitted by the district court in this case; Revere has not disputed this admission.

Other courts have suggested various measures for evaluating the admissibility of such extra-administrative record evidence. *See, e.g., Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1023–25 (4th Cir.1993) (en banc). But we need only note, not decide the issue. The evidence here was inadmissible, inter alia, because the other evidence plaintiff advances is largely evidence collected after or evidence of his condition after Revere's final decision on January 10, 2002.

D. Discovery

[13] Orndorf also argues the district court should have provided him with discovery "to determine whether the

Revere claim staff and medical reviewers followed procedure and were properly educated, trained and qualified."

The district court invited Orndorf to make a more specific showing of the pertinence of the request, but he did not. The court was correct to deny discovery. There was no serious claim of bias or procedural misconduct toward Orndorf. As we said in *Liston*, "at least some very good reason is needed to overcome the strong presumption that the record on review is limited to the record before the administrator." *Liston*, 330 F.3d at 23. This is true as to discovery as well, regardless of whether the standard of review is de novo or deferential.

IV.

Turning to review of the record, we summarize the evidence.

A. The Duties and Job Requirements of a Perfusionist

In 1995, in connection with his first disability claim, Orndorf filed an occupational report with Revere detailing the physical demands of his job. He noted that he frequently had to stoop and bend; occasionally had to reach above his shoulder level; continuously needed manual dexterity; occasionally had to lift 50 pounds; never had to carry; and had to both sit and stand for 5 hours. He described his most important or essential function as "operating a heart lung machine during open heart surgery," and he left blank the space for "additional comments on physical requirements." Revere does not dispute that Orndorf's "own occupation" was that of a perfusionist, and does not dispute his characterization of the physical requirements of his job.

An Employability and Earning Capacity Evaluation[11] which was admitted into evidence by the district court describes the job of a perfusionist:

> Sets up and operates heart-lung machine in hospital to take over functions of patient's heart and lungs during surgery or respiratory failure. Reviews patient medical history and chart, and consults with surgeon or physician to obtain patient information needed to set up heart-lung machine and associated equipment. Selects, assembles, sets up, and tests heart-lung machine to ensure that machine and associated equipment function according to specifications. Operates heart-lung machine to regulate blood circulation and composition, to administer drugs and anesthetic agents, and to control body temperature during surgery or respiratory failure of patient. Monitors and observes operation of heart-lung machine and patient's physiologic variables such as blood temperature, blood composition, and flow rate, and adjusts equipment to maintain normal body functions. Cleans and adjusts parts of heart-lung machine.

The report classifies the perfusionist's job as "medium work" according to the Department of Labor, meaning that it involves exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently. The report notes that the job involves lifting filled blood lines and buckets of ice weighing up to 50 pounds. The other

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[11]The district court admitted this report only for the limited purpose of clarifying the duties of a perfusionist, and struck other portions of the report.

physical demands include stooping, occasionally; crouching, occasionally; reaching, constantly; handling, constantly; fingering, constantly; feeling, occasionally; and talking, frequently.

B. Evidence in the Record of Orndorf's Back, Neck, and Ankle Pain and Treatment:

Orndorf first sought treatment for back pain in 1976. While serving in the Air Force, he sought treatment in September of 1978 at the Andrews Air Force Base Spine Clinic and in July of 1979, after injuring himself while jumping out of a moving car. X-rays taken in July of 1979 indicated that he had 50 percent loss of disc space between L4–L5 in his spine. The next record of treatment for back problems was on October 23, 1992, approximately ten months after Orndorf started as a perfusionist at Jersey Shore. At this visit, he complained of ''recent low back pain'' after he weight lifted 350–400 pounds.

In December 1993, Orndorf had an MRI of his lumbar spine. The radiologist report noted that ''[t]here is a central and left sided disc herniation at the L4–L5 level. There are degenerative disc changes of this disc with a decrease in the disc space height and some loss of signal intensity of the disc.'' The impression of the radiologist was ''central and left sided disc herniation with prominent degenerative changes at the L4–L5 level. No evidence of lumbar spinal stenosis.''

In January of 1994, Orndorf sought medical attention for low back pain. The treating physician noted that Orndorf had ''[a]dvanced degenerative changes with small disc fragment at 4–5 interval with secondary changes at the 3–4 interval.'' He recommended ''strong rehabilitative program'' and a series of epidural injections. Orndorf claims

to have received a series of three epidurals at Jersey Shore Medical Center, although there are no medical records of these treatments. On March 8, 1995, Orndorf went to a clinic complaining of chronic low back pain, which he claimed was aggravated from standing and walking. He was offered an orthopedic evaluation and a rehabilitation/ medical evaluation, both of which he declined; he accepted a prescription for percocet.

From March 29, 1995 to April 3, 1995, Orndorf again complained of back pain during his stay at the Cooley Dickson Hospital Psychiatric Program, where he was hospitalized after a drug overdose. The discharge summary noted that during his hospitalization, Orndorf complained of back pain, but this pain was "found to be controllable with Tylenol and stretching exercises."

There is no evidence that Orndorf was treated for or experienced low back pain after his release from the hospital in April of 1995 to June of 1996. In June 1996, Orndorf was involved in a slow speed car accident and complained of low back strain. While a Lumbosacral Spine exam showed narrowing of the L4–L5 disc, possibly with associated spinal stenosis or disc herniation, the radiologist thought it "very unlikely" to be related to the car accident.

In September 1996, Orndorf was again treated for back pain, at the Veterans Administration ("VA") Medical Center complaining that he could not stand for more than half an hour. The impressions of the physician seeing Orndorf included "chronic low back pain" and herniated discs between L4 and L5. Orndorf was referred to physical therapy and rehabilitation; the recommended plan included weight reduction and use of a TEN's unit (a portable physical therapy device) for a period of four weeks.

Orndorf then started a course of physical therapy and pain treatments. During the September 30, 1996 session, he reported that the TEN's Unit worked "great." On October 31, 1996, Orndorf was treated with an epidural block. He reported he obtained 2–3 months relief with past epidural blocks. On November 5, 1996, he again reported good results from the epidural block, and on December 6, 1996, his physician noted that his low back pain was stable.

There is no evidence that he was treated for or experienced low back pain from November 1996 to December 1997, with the exception of a letter from a physician stating that Orndorf was unable to perform a stress test because of low back pain.

On December 4, 1997, Orndorf was treated again for complaints of low back pain. He was to receive an epidural block and have physical therapy for a few weeks. He went for physical therapy on December 5, 8, 11, and 15, 1997, but did not show up for his appointments on December 17, 19, and 22. The treatment plan was terminated on December 22 due to his failure to keep his appointments.

On January 9, 1998, Orndorf saw an orthopedist. On the questionnaire form, he indicated that he had experienced back pain "off and on" since 1976. He noted that he could not stand for a long time and that the pain was severe. However, he also indicated that pain medicines, arthritis medicines, physical therapy, heating pads, nerve stimulation, and cortisone injections all "improved" his back pain. The orthopedist's form indicated that in general, Orndorf appeared healthy, and that epidurals gave him "2 months to a year's relief—pain comes back gradually." The orthopedist noted the "good results of epidural injections."

On June 23, 1998, Orndorf informed a Revere field representative that his addiction and his bi-polar disorder were well controlled. He noted that he was aware his benefits for this disability would end, but that his chief disabling condition was his back and that his claim for long term benefits would extend beyond the 60 months.

On July 27, 1998, Orndorf again visited a doctor with complaints of low back pain. The treatment included continuing physical therapy and referral to a pain clinic for an epidural block. Orndorf reports that in the summer and fall of 1998, he went to the VA pain clinic for three epidurals.

From August 1998 to June 1999, there is no record of Orndorf being seen by a physician or receiving any treatment for low back pain. At the end of June 1999, he once again went to a physician with a chief complaint of low back pain. Dr. Richard Norris noted that the most likely origin of the low back pain was an accident in 1976. Dr. Norris noted severe narrowing in disc space and disc herniation. The doctor observed that Orndorf's "gait is minimally antalgic on the left. He has moderate restriction of range of motion of the lumbar spine." Dr. Norris noted that Orndorf had a "severe discogenic disease at L4–5."

Orndorf claims that in November of 1999, his back pain caused him to fall down the stairs and that he was seen at the VA clinic. There are no documents verifying this event.

On January 23, 2000, Orndorf went to the VA clinic after regular office hours with a complaint of back pain exacerbation from standing too long. The physical examination revealed that he had mild tenderness in the mid-lumbar area, no fluctuance, no radiation, and normal gait.

The examiner noted no evidence of back muscular spasms. The examiner offered Motrin to the patient, which was refused. The examiner told Orndorf that he could not schedule a CT Scan and informed Orndorf that due to the chronic nature of this problem, he should contact his primary care physician the next morning, who might better be able to serve him. The examiner noted that Orndorf was upset when he could not receive narcotics after hours.

Orndorf did schedule a CT Scan with the VA Medical Center, which was performed on March 8, 2000. The radiologist's impressions from the scan were "[m]oderate degenerative disc disease [at] L4–5 causing mild central spinal stenosis."

In contrast to the extensive medical records of Orndorf's treatment for back problems, the record contains little evidence of Orndorf's neck or ankle problems. Orndorf broke his ankle in 1974 while serving in the Air Force. In 1999, he sprained the same ankle, but was physically impaired only briefly. A CT scan report of Ordnorf's ankle dated May 4, 2000 notes, "marked narrowing of the talotibial joint... degenerative changes with spurring and sclerosis involving the distal tibia[,]... the medial and lateral malleolus... and plantar clacaneal spurring."

As for his neck pain, Orndorf suffered a cervical fracture in 1978, and a cervical strain associated with an automobile accident in June 1996. A report of an X-ray taken on Orndorf's neck on May 12, 2000 states "cervical spondylosis at the C5–C6 level with mild encroachment of the intervertebral formina [and] loss of normal cerival curvature compatible with muscle spasm."

There is no additional evidence for treatment of back, neck, or ankle problems.

C. Evidence in the Record of Orndorf's Physical Limitations and Capacity to Work

In May of 1995, when Orndorf submitted his first claim for disability, he did not report back pain or any other physical limitation that affected his ability to perform his job as a perfusionist. He noted that his only sickness was "drug related," and in response to the question of how the "disability [has] interfered with the performance of the job?... Please describe sitting, standing and walking requirements and limitations," Orndorf wrote only, "judgment." The physician who completed the Attending Physician's Statement ("APS") for the first claim also did not identify any physical limitations on Orndorf's capacity to work.

In his evaluation for vocational rehabilitation on June 26, 1995, Orndorf reported that he had no physical disabilities, but did suffer from hypertension. Also, in December of 1995, Orndorf told a Revere claims department agent that he was interested in working and that he would do laborer work, but not forever. On March 12, 1998, Orndorf was "think[ing] about" returning to work as a perfusionist, and in an April 1998 psychotherapy session he was "struggling with work issues... as he starts to cope with the idea of his insurance getting cut off eventually."

Orndorf's psychotherapy notes of June 11, 1998 reference his recent long bicycle ride and sweat lodge ceremony and note that he was engaging in physical activities. On June 23, 1998, a Revere field representative observed that Orndorf had a bike or ski rack on the top of his car and lived in a second floor walk up apartment; however, the only outdoor activity that Mr. Orndorf admitted to was taking short walks. Orndorf's psychotherapy notes on July 2, 1998 indicate that he had been on "some bicycle trips."

On September 22, 1998, a Social Security Administrative Law Judge ("ALJ") found that Orndorf was "entitled to a Period of Disability commencing March 28, 1995, and to Disability Insurance Benefits under Section 216(i) and 223, respectively, of the Social Security Act." The ALJ relied on the findings of the April 1996 and November 1997 physical examinations of Orndorf by Dr. Tonelli, a Disability Determination Services staff physician. Dr. Tonelli found that Orndorf's low back pain was severe. He assessed that Orndorf retained the ability to lift and carry up to 10 pounds frequently and 20 pounds occasionally; sit, stand, and walk without restriction; and perform unlimited pushing and pulling. Dr. Tonelli believed that Orndorf could perform occasional climbing, balancing, stooping, kneeling, crouching, and crawling.

Another Disability Determination Services staff physician, Dr. Oscar Cartaya, concurred with the opinion of Dr. Tonelli except he found the claimant could perform frequent balancing, kneeling, crouching, and crawling. The ALJ determined that due to a combination of back impairment, hypertension, cardiac impairment, bipolar disorder, and a mixed personality disorder, Orndorf had impairments which made it impossible for him to return to his former employment or make an adjustment to other work, as of March of 1995.

The ALJ found that "as a result of his mental impairments, [Orndorf] would be markedly limited in his ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and moderately limited in his ability to maintain attention and concentration for extended periods and to perform at a consistent pace without an unreasonable number and length of rest periods." She also found physical limitations consistent with Dr. Tonelli's analysis. The ALJ noted that

Orndorf's drug addiction was "not a contributing factor material to the determination of disability."

Orndorf's APS of August 1998, which was signed by Dr. Hashimi, Orndorf's psychiatrist, states that Orndorf is totally disabled from his job and has been totally disabled from July 13, 1979 to the present. The diagnosis listed is bipolar disorder. On November 18, 1998 Revere received the last APS regarding Orndorf, also from Dr. Hashimi. The space for diagnosis was left blank. Orndorf's November 24, 1998 psychotherapy note indicates that one of his hobbies was exercising.

In June 1999, Orndorf reported to Dr. Norris that he rides a bicycle one to two times a week for two to three hours, and that during the past several years he had received six to seven epidurals with varied results. These would bring him relief up to three to four months.

On October 3, 2000, Orndorf submitted to Revere a letter from Dr. Mark Gilbert dated September 12, 2000. The letter was addressed "To Whom It May Concern" and read as follows:

> Jacob Orndorf is a 45 year-old man disabled because of back pain. He first injured his back in 1976. Since then, he has seen a variety of specialists and has had a variety of treatments for progressive incapacitating back pain. At this time, he says that he cannot stand more than a few minutes, cannot sit for over half an hour, and has to lie down several times during the day because of pain. MRI done in 1993 shows central and left-sided disc herniation with prominent degenerative changes at the L4–L5 level. He currently is 40% service-

> connected for back pain and says that he is receiving Social Security disability. Because of this, I consider him disabled for sustained work.

Orndorf also submitted a functional capacity form filled out by Dr. Gilbert. It is not clear whether Dr. Gilbert completed the form from a physical examination or only from Orndorf's verbal answers to the questions. Although the form is not dated, Orndorf claims it is from September of 2000. It states that in an eight hour day, Orndorf can sit for one hour at a time and stand or walk for one-quarter of an hour at a time. It indicates that Orndorf can occasionally lift or carry up to 20 pounds but can never lift or carry over 20 pounds. The form says that Orndorf can never squat, crawl, or climb.

On November 21, 2000, Orndorf was determined disabled from any employment by the Department of Veterans' Affairs as a result of on ankle fracture and hypertension effective October 22, 1997. The report found that his ankle was 20% disabling— the highest evaluation assigned for limitations of motion for an ankle—and that he had limited motion of the ankle.

V.

[14] In light of this evidence and the burden being on the claimant to establish disability, we consider Orndorf's primary arguments that the decision to deny benefits was wrong.

First, Orndorf argues that the reasons relied on by Revere are simply untrue, including the statement that Orndorf's lumbar disc disease was "with intermittent symptomatic exacerbation without evidence of continuous or

persistent ongoing or persistent impairment through the life of the claim, at or about the 12/21/99 determination letter or subsequently" and the statement that "we found no evidence of back problems... during the year 1998."

Second, he argues Revere's reasons for denying his claim are without support in the record and fail to take into account certain evidence about the duration and constancy of his back pain. Specifically, he argues Revere did not credit the disability determination of the Social Security Administration, the Veteran's Administration, or Orndorf's physician, and that Revere did not perform its own medical examination.[12]

[15, 16] We do not read the denial of benefits to have ignored significant material evidence submitted by Orndorf. The denial letter need not detail every bit of information in the record; it must have enough information to render the decision to deny benefits susceptible to judicial review. When the standard of judicial review is de novo, then the administrator, of course, runs a greater risk of reversal if there is little discussion of the evidence about disability. The discussion here of the reasons to deny benefits, as recounted

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[12]Orndorf makes a variety of other arguments concerning Revere's decision that Orndorf was not disabled. First, he argues that while administrators are not required to credit a treating physician's assessment, Revere must offer a reason why it did not credit his statement including either collusion by treating physician or a reasonable basis for rejecting his opinion. He argues that Revere did not refer back to the duties of the perfusionist, or specifically make any determinations as to whether Orndorf could perform the duties of perfusionist, his own occupation. These types of arguments are relevant when performing arbitrary and capricious review to determine whether the decision was reasonable. On de novo review, we reach our own decision based on the administrative record; Orndorf's obligation at this point is to carry his burden to establish that he is disabled under the plan.

above, was considerable. The opinion of the claimant's treating physician, which was considered, is not entitled to special deference. *See Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 831, 123 S.Ct. 1965, 155 L.Ed.2d 1034 (2003).

[17] Orndorf's claim that Revere did not have its own physician *examine* Orndorf, as opposed to reviewing records, does not establish his case. Denials of benefits may be based on review of medical records submitted by the claimant. Orndorf's claim was thoroughly reviewed by a board certified internal medicine physician. And this is simply not a case where the only medical evidence ran in Orndorf's favor, thus casting into doubt a denial of benefits.

To the contrary, the evidence runs against Orndorf's claim of physical disability. This case turns not on the question whether plaintiff suffered back, ankle, or neck pain. The evidence is that he did suffer at least back pain. The medical reports clearly show back problems and the patient's reports of back pain over time. This case turns on whether he met his burden of showing that this back pain disabled him from performing his job as a perfusionist. These records do not establish that these problems disabled Orndorf from performing the duties of a perfusionist. On de novo review, we conclude that Orndorf did not meet his burden. Indeed, from the evidence, several dominant themes emerge.

First, Orndorf actually worked as a perfusionist without any physical limitations despite twenty years of back pain and treatment. Even as late as January 1994, Ordnorf complained to a doctor of "longstanding" low back pain, yet he continued to perform his job for another 14 months without any physical limitations or claims of disability.

Second, when Orndorf stopped working in 1995, it was not because of back pain, but because of his drug dependency. Indeed he did not at this time attribute his disability to back pain. Orndorf himself noted on the claims form that he filled out for his first claim of disability that he had no physical limitations and his only disability was drug dependency.

Third, even after he stopped working in 1995, this back pain was controllable and it did not prevent him from working. During his stay at the Cooley Dickson Hospital in 1995, the doctor noted that Orndorf complained of back pain, but that the pain was controllable with a common pain reliever and stretching exercises. In Orndorf's vocational rehabilitation evaluation, he reported no physical disabilities, and in December of 1995, Orndorf told a Revere representative that he would perform laborer work. In March of 1998, Orndorf became concerned about his ability to survive on disability, and he was considering returning to work as a perfusionist. Indeed, he reported in 1996 and 1997 that various pain therapies for his back were working.

Fourth, Orndorf engaged in recreational and life activity inconsistent with his claim of disability. The notes of Orndorf's psychotherapist suggest that Orndorf was taking bicycle rides and engaging in physical activity. In 1998, he lived on the second floor and had a bicycle rack on his car.

Fifth, even the 1998 Social Security Administration determination of disability did not establish disability from his job as a perfusionist due to his back problems. Rather, the disability finding was based on a combination of factors including hypertension, cardiac impairment, bipolar disorder, and mixed personality disorder. The same is true of the Veteran's Administration report.

Sixth, the back disability claim was not made at all until Orndorf had only two years of disability payments remaining from his drug dependency claim. Orndorf's claim for back disability followed his expressed concerns with work issues "as he start[ed] to cope with the idea of his insurance getting cut off eventually."

In light of this, the most reasonable view of the evidence is that Orndorf does not meet the definition of disability by a physical condition.

The award of judgment to the defendant is ***affirmed***. No costs are awarded.

Report of the
Targeted Multistate Market Conduct Examination
As of December 31, 2002 ("Initial Review") and
February 29, 2004 ("Follow-Up Review")

For

Maine Bureau of Insurance
Massachusetts Division of Insurance
Tennessee Department of Commerce and Insurance

And

Forty-Nine Participating Jurisdictions: Alabama, Alaska, American Samoa, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming

Of

Unum Life Insurance Company of America
NAIC Company #62235
Portland, Maine

The Paul Revere Life Insurance Company
NAIC Company #67598
Worcester, Massachusetts

Provident Life and Accident Insurance Company

A-40

NAIC Company #68195
Chattanooga, Tennessee

NAIC Group #0565

November 18, 2004

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November 18, 2004

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To: The Chief Insurance Regulator of Each of the Jurisdictions Participating in the Targeted (Disability Income) Multistate Examination

Dear Superintendent Iuppa, Commissioner Bowler, Commissioner Flowers and the Chief Insurance Regulators of the Participating States:

Pursuant to the authority granted by Section 24-A *Maine Revised Statutes Annotated,* Chapter 175 *Massachusetts General Laws* Section 4 and *Tenn. Code Ann.* § 56-1-408, your instructions, and in accordance with the *NAIC Handbook on Market Conduct Examinations,* a targeted multistate examination has been conducted of the disability income claim handling practices of:

Unum Life Insurance Company of America ("Unum")
The Paul Revere Life Insurance Company ("Revere")
Provident Life and Accident Insurance Company ("Provident")
(collectively, the "Companies")

The report of examination is herewith respectfully submitted.

Foreword

The report on the targeted multistate market conduct examination of the Companies is provided pursuant to the *NAIC Market Conduct Examiner's Handbook, Chapter VI.* This report is made by exception, i.e. it omits discussion of those claim files reviewed during the examination that did not show improprieties.

Background and Scope of Examination

On January 7, 2003, the Massachusetts Division of Insurance initiated a targeted market conduct examination of the individual disability income ("IDI") claims handling practices of Revere. That examination was organized into two phases. The first phase involved the review of Revere's IDI policy forms, claim administration manuals, claim training manuals, claim administration and organizational charts. The second phase of the examination involved the review of a random sample of 100 IDI claim files, the selection methodology for which is described in further detail below.

The Tennessee Department of Commerce and Insurance had initiated a market conduct examination of Provident's disability income business as part of its financial examination as of December 31, 2000. The market conduct examination focused on litigated disability income claims. The resulting examination report did not refer to market conduct issues due to the initiation of the multistate examination described below.

On September 2, 2003, a multistate targeted market conduct examination was commenced by the Maine Bureau of Insurance, the Massachusetts Division of Insurance and the Tennessee Department of Commerce and Insurance concerning, respectively, Unum, Revere and Provident. Each domiciliary state acted as the Lead State (as defined in the *Market Conduct Examiners Handbook* adopted by the National Association of Insurance Commissioners ("NAIC")) for its respective domiciled company, and the other two Lead State chief regulators were Active Participants. All fifty states, the District of Columbia and American Samoa chose to act as Participating States in the multistate examination.

The multistate examination addressed claims handling practices for both IDI and group long term disability ("LTD") policies. The first phase of the multistate examination involved the review of policy forms, claim administration manuals, claim training manuals, claim administration and organizational charts. The second phase of the multistate examination involved the review of a random sample of 200 Provident and Unum claim files, the selection methodology for which is described in further detail below. After the completion of the second phase of the multistate examination, an update review of a random sample of 75 additional Provident, Revere and Unum claim files was performed, as further described below.

The purpose of the multistate examination was to determine if the disability income claims handling practices of the Companies reflected systemic "unfair claim settlement practices" as defined in the *NAIC Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance Model Act* (1972) or *NAIC Claims Settlement Practices Model Act* (1990) (collectively, the "Model Act"), and particularly, as defined in ME. REV. STAT. ANN. tit. 24-A, § 2164-D(3), (4) & (5); MASS. GEN. LAWS ch. 176D, § 3; and TENN. CODE ANN. § 56-8-104(8). The claim file reviews were conducted in the Worcester, Massachusetts and Glendale, California offices of the Companies during the months of June, November and December 2003 and April 2004.

Profile of the Companies

Unum, Revere and Provident are subsidiaries of UnumProvident Corporation ("the Parent Company"), a Delaware corporation. The Parent Company is the result of a merger between Unum Corporation and Provident Companies, Inc. on June 30, 1999. Previously, on March 27,

1997, Provident Companies, Inc. had acquired The Paul Revere Corporation. The four primary operations centers for the Companies are located in Chattanooga, Tennessee, Portland, Maine, Worcester, Massachusetts and Glendale, California.

Unum, a Maine corporation, primarily markets short term disability and group and individual long term disability insurance as well as long term care insurance and group life insurance. It is licensed to transact business in the District of Columbia and all states, except New York. Revere, a Massachusetts corporation, primarily markets individual long term disability insurance. Revere is licensed to transact business in all fifty states and the District of Columbia. Provident, a Tennessee corporation, primarily markets individual long term disability insurance as well as life insurance through an employee-paid voluntary benefits program. It is licensed to transact business in the District of Columbia and all states, except New York.

The Parent Company uses common management and processes in the administration of the business for Unum, Revere and Provident as well as for its New York subsidiary, First Unum Life Insurance Company. Specifically, the UnumProvident Companies adjust claims for each member insurer from common locations using common procedures. The issues identified by the Multistate Examination are therefore assumed to also be present for each member company. The Companies and their New York affiliate are ranked first in market share – based on annual premium – in both IDI and LTD insurance and in group short term disability insurance, according to the 2003 JHA U.S. Group Disability Market Survey and the JHA 2003 U.S. Individual Disability Market Survey published in April 2004.

Claim Selection Methodology

The multistate examination team requested the Companies to provide a comprehensive database including all claims closed during 2002. Initially, 300 claim files randomly selected from IDI and LTD claims closed during 2002, or for which benefit determinations were appealed or litigated during 2002, or claims open as of year-end 2002 were reviewed (the "Initial Review"). The Initial Review comprised 100 claims each for Unum, Revere and Provident. The proportion of selected IDI and LTD claims was based on the relative reported reserves for each company as of December 31, 2002. Based upon representations by the Companies that a number of changes in claim administration were implemented during 2003, the examination team subsequently reviewed 75 claim files (25 each for Unum, Revere and Provident) which were randomly selected from the Companies' IDI and LTD claims for which benefit determinations were *first* appealed during the period of December 2003 through February 2004 ("the Follow-up Review"). Exhibit "A" depicts the distribution of such claims by company, by line of business and by category for both the Initial Review and the Follow-up Review, including the total number of claims in the population, and the claims randomly selected for review. Exhibit "B" depicts the distribution of the claims included in the Initial Review by the state of residence of the claimant. Exhibit "C" depicts the distribution the claims included in the Follow-up Review by the state of residence of the claimant.

Areas of Concern

The Initial Review of 299 claim files (the Companies were not able to locate one claim file which had been selected for review) noted several general areas of concern, which applied to the Companies' handling of both IDI and

LTD claims. The examination team identified no material differences in claim handling among the individual companies or among their claim offices. The general areas of concern included the following:

1. *Excessive reliance upon in-house medical professionals*: The Companies have invested significant resources in the creation of a staff of physicians and nurses whose function is to provide support to and education of claim handling personnel. These in-house medical professionals include both full-time and part-time employees. The Companies also use the services of medical professionals who are independent contractors. These medical professionals review medical records of claimants and provide interpretation and analysis of such records to the claim staff who are ultimately responsible for making the claims decisions. In certain instances, in-house medical professionals will interact by telephone or by correspondence with attending physicians or other treatment providers of the claimants. In so doing, their objective is to determine whether sufficient medical evidence exists for restrictions and/or limitations which will be used to determine if the claimant meets the policy's definition for total, partial or residual disability. In-house medical professionals do not examine or otherwise interact with claimants directly. The Companies' insurance contracts generally allow the Companies to require claimants to submit to an independent medical examination ("IME") conducted by a physician of the Companies' choice. The examination team identified numerous instances in which the Companies relied heavily upon the analysis of their in-house medical professionals, and refrained from securing an IME. In many such instances, the Companies discounted or disputed the opinions of claimants' attending physicians, but chose not to invoke the requirement that the claimant attend an IME. Where there is conflicting medical evidence or

conflicting medical opinions with respect to a claimant's eligibility for benefits, the Companies have the ability to invoke the policy provision and obtain an IME, and should do so.

2. *Unfair construction of attending physician or IME reports*: The Companies' excessive reliance upon in-house medical professionals also suggests the Companies' employment of such professionals often resulted in a Company bias and the inappropriate interpretation or construction of medical reports, to the detriment of claimants. In certain instances, this bias was reflected in the interpretation of attending physicians' statements or medical records supplied by attending physicians. In other instances in which the Companies had obtained an IME, the reports supplied by the IME providers were narrowly or even incorrectly construed. The bias of the in-house medical professionals was also reflected in attempts to focus upon any apparent inconsistencies in the medical records or other information supplied by claimants, rather than attempt to derive a thorough understanding of the claimant's medical condition.

3. *Failure to evaluate the totality of the claimant's medical condition*: The examination team identified instances in which claimants who suffered from multiple medical conditions were denied benefits as a result of the Companies' apparent failure to properly evaluate the cumulative effects of such conditions. In some instances, the Companies' failure to properly evaluate such "co-morbid" conditions appeared to stem from an excessively narrow focus upon the specific medical condition for which benefits had originally been sought by the claimant. By way of example, certain claimants exhibited a psychological "overlay" which was related to or may have resulted from an underlying medical condition. Although the Companies'

claim handling may have included an evaluation of each separate condition, there was an insufficient effort made to assess the disabling effects of the conditions cumulatively.

4. *Inappropriate burden placed on claimants to justify eligibility for benefits*: The examination team identified a significant number of instances in which benefits were denied by the Companies on the grounds that the claimant had failed to provide "objective evidence" of a disabling condition. The Companies' policy forms do not require the claimant to provide such evidence. Alternatively, the Companies in certain instances denied eligibility for benefits on the grounds that the claimant had failed to submit particular medical test results which were deemed by the Companies to be critical to an evaluation of the claim. In such instances, the Companies could have obtained such test results by ordering an IME and requesting that such tests be performed by the IME provider. In general, the examination team found evidence of the Companies' effort to "shift" the burden of responsibility to the claimant to provide medical or other records in support of the claim, rather than obtain such records through the use of authorizations executed by the claimant. These practices are particularly of concern for claimants whose medical conditions may be interfering with their ability to interact with the Companies' staff in the handling of their claims.

Following completion of the Initial Review, representatives of the Lead States and the examination team met with representatives of the Companies in February 2004 to review the foregoing areas of concern as they related to specific claims which had been identified for discussion. After additional explanation was provided by the Companies, the examiners and the Lead States concluded that the level of claim handling errors identified was sufficient to merit further review and regulatory action.

Following that meeting, the Lead States concluded that the examination team should perform the Follow-up Review. The objective of the Follow-up Review was to assess the impact of claim administration changes reportedly implemented by the Companies during 2003, specifically with respect to the areas of concern. For that reason, 75 claim files were randomly selected from the population of claims for which a first appeal of an adverse claim determination had been filed during the thee month period from December 1, 2003 - February 29, 2004. Following completion of the Follow-up Review, representatives of the Lead States and the examination team again met with representatives of the Companies to review areas of concern as they related to specific claims which had been identified for discussion. After additional explanation was provided by the Companies, the examiners and the Lead States concluded that the level of claim handling errors identified was sufficient to merit further regulatory action.

After consultation with the Companies' senior management and the Board of Directors of the Parent Company, agreement in principle was reached between the Lead States and the Companies on the Plan of Corrective Action described below. This agreement obviated the need for additional investigation, review of a larger claim sample, specific claim findings or reaching a formal conclusion concerning the examination objective, thereby assuring, for the benefit of the Companies' policyholders, prompt implementation of a reassessment plan, changes in corporate governance and changes in claim handling procedures. All of these steps are described in greater detail in the attached Regulatory Settlement Agreement and implementing Consent Orders.

Plan of Corrective Action

The Lead States have designed a Plan of Corrective Action ("the Plan") with the Companies and their New York affiliate, to address the concerns raised by the examination. The Plan will be implemented through a regulatory settlement agreement or consent orders (collectively, "Agreement") entered into by each of the Companies with its Lead State regulator and subscribed to by at least two-thirds of the Participating States, unless a lesser number is agreed to by the Companies, and the United States Department of labor. (Once the Agreement becomes effective, the Lead States are thereafter referred to as Lead Regulators and the subscribing Participating States as Participating Regulators.) In addition, the Companies' New York affiliate, First Unum Life Insurance Company, will enter into a similar agreement with the New York Superintendent of Insurance. This Agreement is supported by the Office of the Attorney General of the State of New York. The Agreement is included herewith as Exhibits "D", "E' and "F". The Agreement provides for a penalty of $15,000,000, will provide for the assessment of substantial fines or other significant regulatory action should the Companies fail to comply with their terms, including the accomplishment of specified improvements in claim administration established in such Agreement. The Lead Regulators will monitor the Companies' (including their New York affiliate) compliance with the terms of the Agreement at the Companies' cost through an established framework of quarterly reports and meetings as well as periodic examination of the reassessment process or general claim handling, and will conduct a full re-examination of the issues addressed by this examination within twenty-four months of the Implementation Date of the Agreement.

The most significant provisions of the Agreement are the following:

A. *Claim Reassessment Process*: The Companies will form a new Claim Reassessment Unit located primarily in their Worcester, Massachusetts and Portland, Maine offices (IDI and LTD claims, respectively), for the purpose of providing a "de novo" review of claims previously denied or terminated pursuant to a review procedure approved by the Lead Regulators. Written notice of this reassessment process will be provided to eligible claimants (as outlined in the Agreement), representing approximately 215,000 claims, whose IDI or LTD insurance claims were denied or whose benefits were terminated on or after January 1, 2000 and prior to the Implementation Date (as defined in the Agreement). The reassessment process will be open to eligible claimants who elect to participate, as well as any other claimants who indicate an interest in participation provided that the claim denial or termination of benefits took place no earlier than January 1, 1997. The Companies' performance will be subject to regulatory scrutiny and monitoring, and the claim reassessment process will be subjected to independent review by agents of the Lead Regulators.

B. *Changes in Claim Organization and Procedures*: The Companies will implement changes to its claim organization and claim procedures with the following objectives:

- The engagement of experienced claim personnel at the earliest possible stage of claim reviews

- Increased emphasis upon claim staff accountability for compliance with the terms of insurance policies and applicable law

- Increased involvement of higher levels of claim management staff in each claim denial or claim termination decision

- Creation of a separate compliance/accountability function at the claim denial and claim termination level

- Assurance that co-morbid conditions are properly evaluated at every level of claim review

- Increased utilization of IME's

- Additional compliance training for all claim staff, with emphasis upon the results of the multistate examination, the Plan, and the NAIC Unfair Claim Settlement Practices Act; and

- Additional training for group policyholder human resources personnel so as to better facilitate the process for LTD claims

C. *Changes in corporate governance*: The Companies will address regulatory concerns regarding corporate control issues by implementation of the following changes:

- The Board of Directors of the Parent Company will be expanded by three members, each of which will have significant insurance industry or insurance regulatory experience (two will have regulatory experience); each candidate will be approved by the Lead States

- The Audit Committee of the Board of Directors will be expanded by one member; at least one of the

new members of the Board of Directors will be appointed to the Audit Committee

- The Board of Directors will establish a new Regulatory Compliance Committee, comprised of two of the new members of the Board, and three existing independent directors; the Regulatory Compliance Committee will have responsibility for monitoring compliance with the Plan and other compliance-related oversight functions; and

- The Companies will create a Regulatory Compliance Unit, which will report directly to the Regulatory Compliance Committee; the Regulatory Compliance Unit will monitor compliance with the Plan (including the functions of the Claim Reassessment Unit) through the performance of periodic audits, provide assistance to claimants to ease and facilitate the claim submission process, and gather data for the Lead States' ongoing monitoring of compliance with the Plan

D. *Quarterly Meetings between the Lead Regulators and the Companies*: The Lead Regulators and the DOL will meet separately with the Regulatory Compliance Committee of the Parent Company and with senior management of the Companies on a quarterly basis, to evaluate compliance with the Plan. Participating States will be updated quarterly by the Lead Regulators, through the NAIC.

Report Submission

The report of examination is herewith respectfully submitted.

Sincerely,

/s/ J. David Leslie

J. David Leslie
Rackemann, Sawyer & Brewster, P. C.

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Acknowledgement

The assistance of Richard Kelly, an examiner appointed by the State of Nevada, in reviewing certain claim files during the Initial Review, is hereby acknowledged with appreciation.

Exhibit A

UNUMPROVIDENT CLAIM SUMMARY BY COMPANY

UNUM LIFE INSURANCE COMPANY OF AMERICA			
Initial Review			
Line of Business	Category	Claims for Period	Reviewed
Group LTD	Litigated	693	19
	Pending	70,319	19
	Closed	65,200	20
	Appeals	9,502	19
	Sub-total	145,714	77
Individual DI	Litigated	258	6
	Pending	6,087	6
	Closed	2,232	5
	Appeals	217	6
	Sub-total	8,794	23
TOTALS		**154,508**	**100**

UNUM LIFE INSURANCE COMPANY OF AMERICA			
Follow-up Review			
Line of Business	Category	Claims for Period	Reviewed
Group LTD	Litigated		
	Pending		
	Closed		
	Appeals	1,292	19
	Sub-total	1,292	19
Individual DI	Litigated		
	Pending		
	Closed		
	Appeals	20	6
	Sub-total	20	6
TOTALS		**1,312**	**25**

Provident Life and Accident Insurance Company			
Initial Review			
Line of Business	Category	Claims for Period	Reviewed
Group LTD	Litigated	186	5*
	Pending	9,049	5
	Closed	4,872	5
	Appeals	1,406	5
	Sub-total	15,513	20
Individual DI	Litigated	369	20*
	Pending	10,445	20
	Closed	7,549	20
	Appeals	364	20
	Sub-total	18,727	80
TOTALS		**34,240**	**100**

* 25 Litigated files taken from 50 files provided in the 2002 Tennessee financial and market conduct exam

Provident Life and Accident Insurance Company			
Follow-up Review			
Line of Business	Category	Claims for Period	Reviewed
Group LTD	Litigated Closed		
	Pending		
	Closed		
	Appeals	118	5
	Sub-total	118	5
Individual DI	Litigated Closed		
	Pending		
	Closed		
	Appeals	52	20
	Sub-total	52	20
TOTALS		**170**	**25**

Paul Revere Life Insurance Company			
Initial Review			
Line of Business	Category	Claims for Period	Reviewed
Group LTD	Litigated		
	Pending (Open)		
	Closed		
	Appeals		
	Sub-total	0	0
Individual DI	Litigated	284	25
	Pending (Open)	7,750	25
	Closed	3,859	25
	Appeals	200	25
	Sub-total	12,093	100
TOTALS		**12,093**	**100**

Paul Revere Life Insurance Company			
Follow-up Review			
Line of Business	Category	Claims for Period	Reviewed
Group LTD	Litigated		
	Pending (Open)		
	Closed		
	Appeals	58	
	Sub-total	58	0
Individual DI	Litigated		
	Pending (Open)		
	Closed		
	Appeals	34	25
	Sub-total	34	25
TOTALS		**92**	**25**

Exhibit B

Distribution of UnumProvident Claim Selections by State
(Initial Claim Review)

TABLE HEADING KEY:

A Code
B Revere - Individual
C Unum - Individual
D Unum - Group
E Provident - Individual
F Provident - Group
G Provident - Litigation
H Total

State	A	B	C	D	E	F	G	H
ALABAMA	AL	0		1	2		1	4
ALASKA	AK	0						0
ARIZONA	AZ	1		1	2			4
ARKANSAS	AR	0						0
CALIFORNIA	CA	9	1	9	4	1	5	29
COLORADO	CO	3			1	1		5
CONNECTI-CUT	CT	1		1	1			3
DELAWARE	DE	3						3
DISTRICT OF COLUMBIA	DC	1		1				2
FLORIDA	FL	8	4	5	7	1	5	30

State	A	B	C	D	E	F	G	H
GEORGIA	GA	3		4	4	1		12
HAWAII	HI	1						1
IDAHO	ID	0						0
ILLINOIS	IL	5		2			1	8
INDIANA	IN	0		3				3
IOWA	IA	2						2
KANSAS	KS	1		1				2
KENTUCKY	KY	2		2	1	1	1	7
LOUISIANA	LA	2	1	1	2			6
MAINE	ME	0		7			1	8
MARYLAND	MD	1		1	1	1	1	5
MASSACHU-SETTS	MA	4		2	2	1		9
MICHIGAN	MI	0	1	2	6	1	1	11
MINNESOTA	MN	0	1					1
MISSISSIPPI	MS	1			1		1	3
MISSOURI	MO	1		1				2
MONTANA	MT	0						0
NEBRASKA	NE	0		2				2
NEVADA	NV	1		1				2

State	A	B	C	D	E	F	G	H
NEW HAMPSHIRE	NH	0		2				2
NEW JERSEY	NJ	10	4	1	3			18
NEW MEXICO	NM	1						1
NEW YORK	NY	11		2		2		15
NORTH CAROLINA	NC	4		2	1	2	1	10
NORTH DAKOTA	ND	0						0
OHIO	OH	3		4	1			8
OKLAHOMA	OK	1			2			3
OREGON	OR	1	2					3
PENNSYL-VANIA	PA	3	4	4	2	1	1	15
RHODE ISLAND	RI	2	1		1			4
SOUTH CAROLINA	SC	1		4	1	1		7
SOUTH DAKOTA	SD	0						0
TENNESSEE	TN	5	1	2	5	1	3	17
TEXAS	TX	0	1	6	6			13
UTAH	UT	0					1	1

State	A	B	C	D	E	F	G	H
VERMONT	VT	0	1		1			2
VIRGINIA	VA	2			1		1	4
WASHINGTON	WA	2	1	1	1		1	6
WEST VIRGINIA	WV	2						2
WISCONSIN	WI	2		2	1			5
WYOMING	WY	0						0
Total		**100**	**23**	**77**	**60**	**15**	**25**	**300**

Exhibit C

Distribution of UnumProvident Claim Selections by State
(Follow-Up Claim Review)

TABLE HEADING KEY:

A Code
B Revere - Individual
C Unum - Individual
D Unum - Group
E Provident - Individual
F Provident - Group
G Total

State	A	B	C	D	E	F	G
ALABAMA	AL				1		1
ALASKA	AK						0
ARIZONA	AZ						0
ARKANSAS	AR						0
CALIFORNIA	CA	3	1	2	2		8
COLORADO	CO						0
CONNECTICUT	CT	1		1			2
DELAWARE	DE			1			1
DISTRICT OF COLUMBIA	DC			1			1
FLORIDA	FL	3		1	1	1	6
GEORGIA	GA						0

State	A	B	C	D	E	F	G
HAWAII	HI						0
IDAHO	ID				1		1
ILLINOIS	IL	3	1				4
INDIANA	IN				1		1
IOWA	IA			1			1
KANSAS	KS						0
KENTUCKY	KY	1		1	2		4
LOUISIANA	LA			1			1
MAINE	ME	1		2			3
MARYLAND	MD						0
MASSACHUSETTS	MA	1			1		2
MICHIGAN	MI	1			2	1	4
MINNESOTA	MN			1			1
MISSISSIPPI	MS						0
MISSOURI	MO						0
MONTANA	MT						0
NEBRASKA	NE						0
NEVADA	NV						0
NEW HAMPSHIRE	NH						0
NEW JERSEY	NJ	1		1	1	1	4
NEW MEXICO	NM						0

State	A	B	C	D	E	F	G
NEW YORK	NY	2	2	1	2		7
NORTH CAROLINA	NC	1		1	1		3
NORTH DAKOTA	ND						0
OHIO	OH	1	2		1		4
OKLAHOMA	OK						0
OREGON	OR						0
PENNSYLVANIA	PA	3		1			4
RHODE ISLAND	RI						0
SOUTH CAROLINA	SC			1		1	2
SOUTH DAKOTA	SD						0
TENNESSEE	TN	1		1	1		3
TEXAS	TX	1		1			2
UTAH	UT						0
VERMONT	VT						0
VIRGINIA	VA					1	1
WASHINGTON	WA	1			3		4
WEST VIRGINIA	WV						0
WISCONSIN	WI						0
WYOMING	WY						0
Total		**25**	**6**	**19**	**20**	**5**	**75**

(3)

Supreme Court, U.S.
FILED

05-189 JUL 14 2005

No.

OFFICE OF THE CLERK

In The Supreme Court of the United States

Jacob M. Orndorf,

Petitioner,

v.

Paul Revere Life Insurance Company

Respondent

On Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit

SUPPLEMENTAL APPENDIX TO PETITION FOR A WRIT OF CERTIORARI

Jon Holder
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UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTES

JACOB M. ORNDORF,	)	
Plaintiff,	)	
	)	
v.	)	**CIVIL ACTION NO.**
	)	**20-30024-FHF**
PAUL REVERE LIFE	)	
INSURANCE COMPANY,	)	
Defendant.	)	

MEMORANDUM AND ORDER

December 30, 2002

FREEDMAN, S.J.

Plaintiff Jacob Orndorf (the "plaintiff") filed this action against the Paul Revere Life Insurance Company (the "defendant"), to enforce rights under an employee benefit plan regulated by ERISA, 29 U.S.C. § 1132, due to the defendant's refusal to pay long-term disability benefits.

The parties were due to appear for a second case management conference to discuss for a second time those issues relating to the Court's Order of August 6, 2002, "Regulating [the] Proceedings (Judicial Review of Out-of-Court Nongovernmental Decisions)" (the "Order") (Doc. No. 15), as initially raised in the plaintiff's Motion for a Trial De Novo to Resolve All Factual Issues and For Leave to Submit Additional Evidence (Doc. No. 23), and as supplemented by the Plaintiff's more recent Motion to Submit Additional Evidence (Doc. No. 27). The second conference was cancelled due to weather and was to be rescheduled for January 28, 2003.

Upon further consideration, the Court finds a second case management conference to be unnecessary. Instead, this Order will finalize: (1) the standard of review and (2) the record for judicial review (the "Record").

As to the standard of review governing this ERISA case, it appears from the parties' submissions and from the discussions in the first case management conference that both parties agree that there has been no discretionary authority granted to the plan administrator or fiduciary. Therefore, the Court will apply the ERISA de novo review standard. The plaintiff is once again reminded that this case is an ERISA action, not a simple breach of contract action, and the plaintiff should be prepared to proceed accordingly. See Recupero v. New England Tel. & Tel., 118F.3d 820 (1st Cir. 1997).

As to the parameters of the Record which the Court will review, the Order of August 6th contemplated tha the plaintiff would list and show "good cause" for each specific item of evidence he wished to add to the Record, so the Court could determine whether any additional evidence was worthy of inclusion. At the case management conference, the Court once again instructed the plaintiff to list specifically and to show good cause for each item of evidence the plaintiff would like added to the Record. The plaintiff thereafter filed his second motion on this issue in which he vaguely requests to supplement the Record with "vocational evidence" and "medical evidence of a continuing disability" and where he again generally fails to specify what form this evidence will take or its necessity to the Court's review. Based on the vague submissions of the plaintiff, the Court only finds "good cause" to grant supplementation of the Record with the requested report of a vocational expert, which would serve to more clearly outline the duties of Mr. Orndorf's occupation for the Court's greater understanding. Because it remains unclear what specific items the plaintiff is requesting as to additional medical evidence, and because in

his vagueness he has failed to make the required showing of "good cause", the Court is denying the plaintiff's request to supplement the Record with medical evidence of a continuing disability or otherwise.

The Court finds no reason why this case cannot be resolved on cross motions for summary judgment utilizing the ERISA de novo standard as applied to the Record herein established. The plaintiff's motion will be due on January 28, 2003. The defendant's cross-motion will be due on February 28, 2003. Any replies will be due on March 14, 2003.

It is So Ordered.

_____

Senior United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Jacob M. Orndorf,	)	
Plaintiff	)	
	)	
v.	)	**CIVIL ACTION NO.**
	)	**02-30024-MAP**
The Paul Revere Life	)	
Insurance Company,	)	
Defendant	)	

MEMORANDUM AND ORDER REGARDING CROSS-MOTIONS FOR SUMMARY JUDGMENT AND DEFENDANT'S MOTION TO STRIKE
(Docket Nos. 34,36,40 and 45)

March 17, 2004

Ponsor, D.J.

I. INTRODUCTION

Jacob Orndorf ("Orndorf") has sued his former insurance provider, The Paul Revere Life Insurance Company ("Paul Revere"), alleging a two-tiered violation of ERISA. First, Orndorf claims that he was receiving disability benefits related to drug dependency and that Paul Revere terminated those benefits arbitrarily and in breach of its fiduciary duties. Second, Orndorf claims that Paul Revere improperly refused to pay disability benefits he was owed as a result of back, ankle, and neck pain as well as hypertension.

The parties have filed cross-motions for summary judgment.[1] Paul Revere asserts that summary judgment in its favor is warranted because the Administrative Record clearly supports (1) the termination after sixty months of benefits related to drug dependency, and (2) its decision to deny Orndorf's claim for disability benefits for back, ankle, and neck pain as well as hypertension. For the reasons stated below, Paul Revere's motion for summary judgment will be allowed and plaintiff's denied.

Before proceeding, a few words are necessary regarding the procedural history of this case. Unum Provident was originally named as a defendant, but on September 16, 2002, the parties stipulated that Paul Revere was the proper sole defendant and that the case should be captioned accordingly. This case was originally assigned to Senior Judge Frank H. Freedman. Judge Freedman issued a Memorandum and Order dated December 30, 2002 (Docket No. 29) confirming the applicable standard of review as well as the scope of the record to be reviewed; he subsequently issued another Order dated February 20, 2003 (Docket No. 33) denying plaintiff's motion for reconsideration. The parties then submitted their motions for summary judgment

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[1] Plaintiff's Statement of Material Facts in Support of the Motion for Summary Judgment (Docket No. 42) was filed more than two months late. This failure alone would justify denial of his motion for summary judgment. Local Rule 56.1. See Barry v. Wing Mem'l. Hosp., 142 F.Supp.2d 161, 163, n. 1 (D.Mass.2001); Shabazz v. Cole, 69 F.Supp.2d 177, 185-186 (D.Mass.1999). Also, Plaintiff's Memorandum in Support of the Reply to Paul Revere's Motion to Strike (Docket No. 44) was similarly untimely. Local Rule 7.1(B)(2). Because the defendant's position on the merits is so persuasive, it is not necessary to address this procedural default. Therefore, defendant's Motion to Strike Plaintiff's Statement of Material Facts and His Memorandum in Support of His Reply to Paul Revere's Motion to Strike (Docket No. 45) is hereby denied as moot.

(Docket Nos. 34 and 36), and defendant submitted two Motions to Strike (Docket Nos. 40 and 45). A hearing was held before Judge Freedman on July 11, 2003, and the motions were taken under advisement. Following Judge Freedman's tragic and unexpected death in August of 2003, this case was reassigned to me.

II. FACTS

The extensive Administrative Record[2] (the "Record") in this case contains the information Paul Revere relied on in reaching its decision, and the parties do not contest the substance of the Record. Pursuant to Judge Freedman's ruling, Paul Revere's out-of-court decision is subject to *de novo* review. *See* Recupero v. New England Tel. Co., 118 F.3d 820, 827 (1st Cir. 1997); Allen v. Adage, Inc., 967 F.2d 695, 697 (1st Cir. 1992). The facts recited below are drawn from the Record and construed, to the extent possible, in the light most favorable to the plaintiff.

A. The Policy

Paul Revere provided long-term disability insurance coverage to Orndorf's employer, Jersey Shore Cardiac Associates, Inc., under Group Policy Number G-40651 ("the Policy"). The Policy was an employee welfare benefit plan as defined by ERISA. In pertinent part, the Policy provided benefits in the case of "total disability from any occupation," "total disability from the employee's own occupation," or "residual disability." The Policy defined these terms as follows:

> [T]otal disability from the employee's own occupation means: ··· (a) that because of injury or

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2 The Administrative Record is contained in three volumes filed on September 11, 2002.

> sickness the employee cannot perform the important duties of his own occupation; (b) the employee is under the regular care of a doctor, and (c) the employee does not work at all. [T]otal disability may mean either totally disabled from any occupation or totally disabled from the employee's own occupation as shown above. If the employee works full time at his own job, he may be considered to be residually disabled.

Administrative Record ("AR") at 00014. The Policy also defined Paul Revere's obligation to pay a benefit to the insured:

> [Paul Revere] pay[s] monthly total disability benefits to an employee if he becomes totally disabled while insured due to injury or sickness. The employee must be under the care of a doctor while totally disabled···· During any continuous period of disability immediately following completion of the employee's elimination period, but before the end of his benefit period, [Paul Revere] pay[s] the employee a monthly total disability benefit for each whole month in which he is totally disabled from his own occupation. If the employee works other than full-time at his own job, he may qualify for monthly residual disability benefits.

AR at 00018. The limited benefit for any disability caused by a psychiatric disorder, alcoholism, or drug abuse was defined as follows:

> For any disability which is caused by or contributed to by a psychiatric disorder, alcoholism, drug abuse, or the use of any drug other than one administered on a doctor's advice, benefits are payable for up to sixty months whether or not the employee is hospital

> confined. After sixty months, subject to all other policy provisions, [Paul Revere] pay[s] benefits only if the employee continues to be hospital confined due to the disability.

AR at 00025.

B. The Duties of Orndorf's Occupation

Orndorf was employed by Cardiac Associates as a perfusionist-a technician who operates a heart/lung machine during open heart surgery-beginning in 1992. In 1995 Orndorf filled out an Occupational Description form in which he indicated that as a perfusionist he worked eight hours per day and was required to bend and stoop frequently (1.5 to 5.5 hours), lift as much as fifty pounds on occasion, and sit and/or stand for as much as five hours at a time. Paul Revere does not dispute Orndorf's employment as a perfusionist or Orndorf's statement of the physical duties of a perfusionist.

C. Orndorf's First Claim for Disability Benefits Related to Drug Dependency

On March 28, 1995, Orndorf was admitted to a hospital in New Jersey following an intravenous drug overdose that led to respiratory arrest. He was transferred to Cooley Dickinson Hospital in Northampton, Massachusetts on March 29 and was discharged on April 3.

On April 25, 1995, Orndorf submitted his first claim for disability benefits, principally including a completed form entitled "Claimant's Statement for Disability Benefits." The form requested that the claimant provide a variety of information, including the following:

> 1) "Describe how, where, and on what date [the accident] occurred and what injury resulted." Orndorf provided no information in response.

2) "Give the nature and details of sickness." Orndorf's response was "drug related."
3) "How has disability interfered with the performance of the job? Please describe sitting, standing and walking requirements and limitations." Orndorf's response simply was "Judgement."

AR at 00006. At the time he filed his first claim for disability benefits in the Spring of 1995, Orndorf never alluded to any disability other than his drug dependency; he made no mention of any physical limitations.

Orndorf's first claim also included a form entitled "Attending Physician Statement," in which the attending physician indicated that Orndorf was suffering from opiate dependency and dysthymia. The attending physician recommended rehabilitation as the appropriate treatment and indicated only one limitation-Orndorf should not work in the medical field until further notice.

In considering Orndorf's claim for disability benefits related to drug dependency, Paul Revere reviewed the Admission Note and the Admission History and Physical taken at Cooley Dickinson Hospital on March 29, 1995. Those records indicated Orndorf's history of drug abuse as well as hypertension (for which he was taking Vasotec, Hytrin, and Procardia), anxiety (for which he was taking Xanax), and back pain (for which he was taking Percocet but which was generally under control by taking Tylenol and stretching). Also, Orndorf was diagnosed with ADHD as a child, with a family history of depression and attempted suicide, and had been seeing a therapist. He was mildly to moderately obese.

Paul Revere also reviewed the Psychiatric Evaluation of Orndorf conducted by Dr. Sara Stalman at Hillcrest Hospital in Pittsfield on April 7, 1995. That evaluation indicated a diagnosis of substance abuse, narcotics addiction, dysthymia, severe generalized anxiety disorder, and

hypertension related to panic disorder. The evaluation also indicated that Orndorf was taking Zoloft and Ritalin, and was self-medicating with other drugs.

In June and July of 1995, Orndorf received preliminary vocational assessments and counseling. He expressed a desire to change careers, recognizing that he could no longer work in a hospital setting due to his drug abuse, and considered returning to school to get an MFA in creative writing, but "indicated that he wanted to work full time rather than going back to school at this point in time." AR at 00485.

Paul Revere also commissioned a Psychiatric Assessment of Orndorf, which was conducted by Dr. Stalman on August 17, 1995. She again diagnosed Orndorf with polysubstance abuse, dysthymia, panic disorder, and hypertension related to anxiety. She also indicated that Orndorf was "unable to function around psychoactive drugs/medications (i.e., a healthcare setting)," but was "otherwise functioning normally." AR at 00096. More pointedly, she noted that Orndorf "cannot continue as a perfusionist due to [the] disease of addiction," but that he "could begin retraining immediately;" "except being around psychoactive drugs, [Orndorf] should do what's best for him and his family." AR at 00096. Finally, she noted that Orndorf "needs to be working···· [He] is a highly bright man who should be encouraged to get a job using his skills to help others. Unfortunately he is trained as a perfusionist. He cannot return to that job." AR at 00096.

On August 24, 1995, Paul Revere advised Orndorf that his claim for disability benefits related to his drug dependency had been approved, retroactive to June 26, 1995. Paul Revere also indicated "that disabilities of this nature are subject to a maximum benefit period of 60 months," and so would expire on June 26, 2000. AR at 00108. Paul Revere has satisfied its financial obligation to Orndorf on this claim.